FAX BACK TO 951-530-4801 EMPIRE PHARMACY RIVERSIDE, CA PHONE 951-530-8800

Hyperemesis Treatment Referral Form

DEMOGRAPHICS

PatientName:______________________________________DateofBirth:______________________

Home Phone:____________________Cell:____________________Work:____________________

Address:____

City:____State:________Zip:

FINANCIAL INFORMATION:

Please fax a copy of front and back of all insurance cards if available.

ORDERS Height:________Weight:________Allergies:________________________

Diagnosis: ❑HyperemesisGravidarum ICD-10:021.1
❑ Other:________________________________ICD-10:________________

InfusionOrders: **Duration of therapy:** ❑One year ❑One infusion ❑Other:____________________

- ❑ **Hydration**:❑Banana Bag (NS+10ml Multivitamins QD+1mg Folic Acid QD; Thiamine 100mg x1st 3days)
  ❑ LactatedRingers ❑NormalSaline ❑D5-1/2NS ❑OtherFluid:________________
  ❑ Infuse______Liter(s)IVevery_______day(s) as needed for dehydration, or❑________________
- ❑ **Ondansetron:** ❑8mg IV every 6-8 hours as needed for nausea, or❑____________________
- ❑ **Diphenhydramine:** ❑25mg IV every 6 hours as needed for nausea, or❑____________________
- ❑ **Metoclopramide:** ❑10 mg IV every 6-8 hours as needed for nausea, or❑____________________
- ❑ **Famotidine:** ❑20 mg IV every 12 hours as needed for heartburn r/t vomiting, or❑________________
  - **Or Ranitidine** (based in insurance) ❑50 mg IV every 6-8 hours as needed, or❑________________
- ❑ **OtherMedication:**____

◆ InfusionReactionManagementperInfusionSolutionsprotocolasneeded.

Nursing Orders:

◆ If no central IV access,RN to insert peripheral IV, rotate site every 72to120 hours or as needed.
❑ Other:____

Lab Orders:

❑ CBCw/diff	❑at baseline, and weekly if duration>2weeks		❑every ______________
❑ CMP	❑at baseline, and weekly if duration>2weeks		❑every ______________
❑ Magnesium, Phosphorus	❑at baseline, and weekly if duration>2weeks		❑every ______________
❑ BMP	❑weekly (if no CMPorderedweekly)		❑every ______________
❑ OB6 Panel (#17029 – yellow, lavender, &pinktubes)		❑onetime	❑every ______________
❑ ❑onetime	❑weekly	❑every ____	

_______________________________________ _______________________
PrescriberSignature *Date*

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Please Print Name

NPI